

# Low-cost or Free Health Insurance for Washington's Kids & Teens



# 1-877-KIDS-NOW

Toll-free (1-877-543-7669)

Operators standing by to help you 8 AM to 5 PM Monday – Friday, or mail in your application today!

Information can also be found on our website: <http://healthykidsnow.net/>

The Washington State Department of Social and Health Services DSHS 22-394(x) (Rev. 7/05)



## Thousands of Kids Under 19 are Eligible

The programs are flexible and cover kids and teens in many types of households.

- Kids with single parents
- Kids with two parents
- Kids with working parents
- Young adults (under 19) living on their own
- Kids living with grandparents, other family or friends

Even kids with pre-existing medical conditions qualify.

## What Kinds of Services are Covered?

The health insurance programs cover a full range of services that all children need to stay healthy. Once your child is eligible, you will get more information on how to get care.

A few services that are covered include:

- Doctor and nurse visits
- Hospital & emergency care
- Dental care
- Prescriptions
- Check-ups and immunizations
- Eyeglasses and hearing aids
- Physical and speech therapy
- Family planning
- Transportation for office visits
- Counseling and more!

## How Do I Find Out if My Kids Qualify?

The process is easy and many working families qualify. Income, family size (*be sure to include a pregnancy as a family member*) and some monthly expenses are reviewed for eligibility. To see if your kids might qualify, follow the easy steps below. Then compare your monthly income to the chart.

### Step 1 Write Down Your Family's Monthly Income (before tax)

- Subtract any monthly work-related child or adult care expenses you pay.
- Subtract all monthly court ordered child support payments you pay for a child living outside the home.
- Subtract \$90 for each working adult in the household.

### Step 2 Compare to See if You Qualify

If your monthly family income is close to the amounts on the chart, your kids may qualify for low-cost or free health insurance!

**Many people can make more income and still qualify. If your income is higher than the chart, please call 1-877-KIDS-NOW for more information.**

Number of People in Family (includes parents and children)	Approximate income per month (after deductions from Step 1)
1	up to \$1,994
2	up to \$2,673
3	up to \$3,353
4	up to \$4,032
5	up to \$4,711
More	Add \$680 for each additional family member

## Applying is Easy!

1. Fill out the application attached to this brochure.
2. Tear off the application page.
3. Detach the envelope from the application.
4. Attach copies of proof of income to application. For example:
  - Pay stubs from the last 30 days;
  - A self-employment worksheet; OR
  - A letter from your employer giving your gross monthly income.
5. Put application inside the envelope.
6. Drop in any mail box! No stamp is needed.

## How Soon Will My Kids Have Health Insurance?

- Kids are considered for free health insurance first.
- Health insurance approved for kids will be effective the first day of the month in which their application is received!
- You will get a letter within 6 weeks letting you know if your kids are eligible.
- When your kids are approved, they can get health care services immediately.
- For faster processing, be sure to fill out the application completely.
- Every six months you will be mailed a form to renew their insurance.

## Great Programs for Washington's Kids

### Medicaid and CHIP

- Low-cost or free coverage.
- Kids are considered for free coverage first.
- Premiums are billed monthly.
- If you have four kids or more, you'll only pay for three premiums.
- Some children may qualify to have unpaid medical bills covered for the last three months.

Income levels are good through March 31, 2006. This chart deals with health insurance for children under 19 only. Other programs with different eligibility requirements are available for families and pregnant women. Call toll-free 1-877-KIDS-NOW to find out more.



## Application For Children's Medical Benefits



This application is for medical coverage only for children and teens under 19. Anyone can apply on behalf of a child. Children may apply on their own behalf. **We will send the person listed in box 1 all follow-up information.** If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you!

Please print in black or blue ink. Do not use pencil. **(List parent, guardian or contact person who will receive follow-up information)**

<b>1</b>	FIRST NAME	MIDDLE INITIAL	LAST NAME		
<b>2</b>	ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
<b>3</b>	MAILING ADDRESS (IF DIFFERENT)	STREET	CITY	STATE	ZIP CODE
<b>4</b>	TELEPHONE NUMBERS	<b>5</b> Do you have trouble speaking, reading or writing English? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	HOME ( )	What language or alternative format do you need? _____			
	WORK ( )	Do you need an interpreter? (If yes, we will help you through an interpreter.) Yes <input type="checkbox"/> No <input type="checkbox"/>			
	MESSAGE ( )	What language do you speak? _____			
		<b>6</b> Does a child under 19 have a medical condition that needs attention right away? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		Is anyone in your home pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		If "yes," who? _____			

### General Information

**7** List family members **living together**.  
(If needed, attach a separate sheet of paper to list more family members.)

NAME (FIRST, MIDDLE, LAST)	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	SOCIAL SECURITY NUMBER * = OPTIONAL	SEX M or F	U.S. CITIZEN YES NO	COMPLETE IF CHILD IS <b>NOT</b> A U.S. CITIZEN		
A. PARENT, GUARDIAN OR SELF			*		<input type="checkbox"/> <input type="checkbox"/>	WAS <b>CHILD</b> GIVEN A DOCUMENT SHOWING STATUS?	LIST DATE CHILD ARRIVED IN U.S.	DOES CHILD HAVE A SPONSOR?
B. SPOUSE OR OTHER PARENT (if living in the home)			*		<input type="checkbox"/> <input type="checkbox"/>	YES NO		YES NO
C. LIST CHILDREN & TEENS UNDER 19 YEARS OF AGE ( <b>who want medical benefits</b> )					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
D.					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
E.					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
F.					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
G. LIST OTHER ADULTS/CHILDREN IN THE HOME ( <b>who do not want medical benefits</b> )			*			Note: Please attach any documents showing children's status.		
			*					

**8** Is a child under age 19 in your household disabled? Yes ☐ No ☐  
If "Yes," who? \_\_\_\_\_

### Expenses This information can help your children qualify.

<b>9</b>	Do you pay for childcare while you work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," how much per month? \$ _____
	Do you pay someone to take care of a disabled dependent adult while you work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," how much per month? \$ _____
<b>10</b>	Do you pay court ordered child support for a child who is not living in your home?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," how much per month? \$ _____

## Income

Enter GROSS pay (before taxes or expenses).

(Please attach proof of income for last 30 days)

<b>11</b> PARENT'S EMPLOYER NAME AND PHONE ( )	<b>15</b> CHILD SUPPORT	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER EARNS THIS INCOME?
<b>12</b> Amount you received in the last 30 days before taxes or expenses were taken out: \$ How much of this income is from self employment?*	<b>16</b> ALIMONY	\$	
<b>13</b> SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND PHONE NUMBER: ( )	<b>17</b> SOCIAL SECURITY PAYMENT	\$	
<b>14</b> Amount your spouse (or other parent living in the home) received in the last 30 days before taxes or expenses were taken out: \$ How much of this income is from self employment?*	<b>18</b> UNEMPLOYMENT BENEFITS	\$	
*IF YOU OR YOUR SPOUSE (OR OTHER PARENT LIVING IN THE HOME) ARE SELF-EMPLOYED, YOU MAY GET OTHER DEDUCTIONS. PLEASE CALL 1-877-KIDS-NOW FOR MORE INFORMATION OR APPLICATION ASSISTANCE.	<b>19</b> INVESTMENT INCOME/INTEREST/DIVIDENDS	\$	
	<b>20</b> VETERANS BENEFITS	\$	
	<b>21</b> LABOR & INDUSTRIES	\$	
	<b>22</b> MILITARY ALLOTMENTS	\$	
	<b>23</b> OTHER (Please explain)	\$	
<b>24</b> Do you need help paying for unpaid medical bills – within the last 3 months – for any of the children you are applying for? Yes <input type="checkbox"/> No <input type="checkbox"/> If “Yes,” please send copies of all household income for the months you would like us to review.			

## Health Insurance Information

Tell us about any health insurance your **children** already have.

<b>25 A</b> Do any of the <b>children</b> you are applying for already have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>25 B</b> If “Yes,” does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>26 A</b> Have your <b>children</b> been covered by job-related health insurance in the last 4 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>26 B</b> If “Yes,” did the premium cost less than \$50 per month for dependents? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>27</b> If you checked “Yes” to any of the above questions (25 a or b or 26 a or b), please list the name of the insurance company or employer providing health insurance for your children.			
INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

## Children's Race/Ethnic Background (Voluntary Information)

We ask you to voluntarily tell us your children's race or ethnic background. This information will not be used in considering your eligibility for benefits.	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other _____	
Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.				

## Read Carefully Before Signing

**This application is for medical benefits for children only.** If anyone in your family already receives, or would like to apply for cash benefits, basic food or other benefits, please contact your local DSHS Community Services Office (CSO).

- DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Service (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- DSHS may share your child's immunization history with the Child Profile Immunization Tracking System.

<b>DECLARATION AND SIGNATURE</b> I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.	<b>Signature of Applicant</b>  X _____ Date _____
---	--

## How to Submit

<b>MAIL TO:</b> Dept. of Social and Health Services P.O. Box 45449 Olympia, WA 98504-5449	<b>FOR HELP:</b> If you need help or have questions, please call <b>1-877-KIDS-NOW.</b> (1-877-543-7669)
---	--

**This application is for medical insurance only.  
If you want to apply for other benefits (like basic food), call 1-877-KIDS-NOW**



- ☐ Did you enclose proof of income for the last 30 days?
- ☐ Did you sign the application?
- ☐ Did you fill in social security numbers for all children applying?
- ☐ If your children are non-citizens, did you attach a copy of their documentation?

**For fastest service, please make sure application is complete.**